INSTRUCTIONS FOR APPLYING TO BECOME A LEAVE RECIPIENT

To qualify for the Leave Transfer Program:

1. You must be absent from duty for a prolonged period of time due to your medical condition or the medical condition of a family member.

2. You must have already been absent or expected to be absent from duty without pay for at least 24 hours. You must already have used or expect to use all of your own accrued annual leave and sick leave. (Note: sick leave need not be exhausted if the medical emergency is that of a family member).

3. Your absence from work must have been approved by your supervisor (i.e., you must have applied for and been approved to be in some sort of approved leave status, such as advanced leave or leave without pay status).

To apply for the Leave Transfer Program:

1. Complete Part I of the Form AD-1046, Leave Transfer Program - Recipient Application.

2. Attach a brief statement to the Form AD-1046 describing your medical emergency, including the nature and severity of the emergency, and expected duration. On this attachment, also explain what your current leave status is and let us know if you have applied for disability retirement or workers' compensation benefits relating to this medical condition.

3. Attach a copy of a medical certificate or doctor's statement which describes the medical condition and which specifies the length of time you will likely be affected by the condition and unable to work. We will accept a copy of the statement you submitted to obtain supervisory approval of your leave, so long as the certificate is current and contains the needed information.

4. Submit the completed application to your immediate supervisor for concurrence. This is required because the supervisor is the leave approving official.

5. Send completed application and attachments to:

Cindy Hadlich or Amy Small
USDA, APHIS, MRP-MBS, LCT
Butler Square West, 5th Floor
100 North 6th Street
Minneapolis, MN 55403
Phone: (612) 370-2369 or (612) 370-2327
Fax: (612) 370-2361

LEAVE TRANSFER PROGRAM - RECIPIENT APPLICATION

FOR PERSONNEL USE ONLY:
CASE NUMBER

INSTRUCTIONS: Use this form to apply to be a leave recipient under Public Law 100-566. Attach to this form a brief description of the nature and severity of the medical emergency and appropriate documentation of the medical emergency: a physician's certificate, the medical prognosis and anticipated duration of the condition. After completing this form, forward through your supervisor to the office in your agency designated to approve leave recipients. **Approval as a leave recipient does not guarantee that leave will be donated. Donor employees will designate the recipient of their leave.**

PART I - APPLICATION AND CERTIFICATION *(To be completed by the applicant or another employee on his or her behalf)*

1. NAME *(Last, First, Middle Initial)*		2. POSITION TITLE		3. SOCIAL SECURITY NUMBER
4. SERIES, GRADE OR PAY LEVEL	5. DUTY STATION	6. ORGANIZATIONAL TITLE *(Agency, Division, Branch, Section)*		
7. OFFICE ADDRESS		8. OFFICE TELEPHONE NO.		9. HOME TELEPHONE NO.
10. NAME OF TIMEKEEPER	11. TELEPHONE NO. OF TIMEKEEPER	12. OFFICE ADDRESS OF TIMEKEEPER		
13. T&A CONTACT POINT NO.	14. ANTICIPATED OR ACTUAL DURATION OF MEDICAL EMERGENCY *(if known)*		15. DATES LEAVE EXHAUSTED	16. AMOUNT OF DONATED LEAVE REQUESTED *(hours, days or months)*
	Beginning Date:	Ending Date:	Annual:	Sick *(if applicable):*

17. PLEASE INDICATE HOW YOU PREFER THE ANNUAL LEAVE DONATED TO BE APPLIED BY NUMBERING THE FOLLOWING IN ORDER OF YOUR PREFERENCE. (Donated annual leave may be applied to retroactively replace leave without pay and / or advanced sick or annual leave in connection with this medical emergency.)

PLEASE INDICATE PAY PERIODS DONATED ANNUAL LEAVE MAY BE RETROACTIVELY APPLIED

____ For current use ____ against advanced annual leave ____ against advanced sick leave ____ against LWOP

18. I agree to have my *(please specify):*

☐ case number only ☐ case number, and circumstances only ☐ name, case number and circumstances

published for the purpose of receiving donations. If I agree to have my circumstances published, the following 5 lines or less describing my medical emergency will be published exactly as I write it and will possibly be made available to employees of my agency who wish to make donations to me.

CERTIFICATION *(If certifying on behalf of another employee, modify as appropriate.)*

I certify that (1) I have been affected by the medical emergency described in the attachment since the date indicated above, (2) I have or will have exhausted all annual leave and any available sick leave that could otherwise be used as of date indicated above, and (3) I expect to be absent from duty without paid leave at least 24 hours because of this medical emergency. I further certify that I am not receiving unemployment benefits or workers' compensation benefits in connection with this medical emergency for which I am requesting transferred annual leave.

SIGNATURE OF RECIPIENT OR HIS OR HER DESIGNEE *(please specify):* ☐ Recipient ☐ Designee				DATE
CONCURRENCE: ☐ Yes ☐ No	SIGNATURE OF SUPERVISOR	TITLE	OFFICE TELEPHONE NO.	DATE

PART II- AGENCY REVIEW AND APPROVAL

1. CURRENT ANNUAL LEAVE BALANCE *(in hours)*	2. CURRENT SICK LEAVE BALANCE *(in hours)*	3. LWOP HOURS USED IN CONJUNCTION WITH THIS EMERGENCY	4. ADVANCED SICK LEAVE HOURS TO DATE	5. ADVANCED ANNUAL LEAVE HOURS TO DATE	6. ANNUAL LEAVE CATEGORY PER PAY PERIOD

APPLICATION APPROVED:

☐ Yes *(If Yes, transferred leave may be credited to the recipient's account effective Pay Period Number):* _____

☐ No *(state reason for disapproval):*

SIGNATURE OF APPROVING OR DISAPPROVING OFFICIAL	TITLE	OFFICE TELEPHONE NO.	DATE

PRIVACY ACT STATEMENT

5 U.S.C. 6311 authorizes collection of this information. Your social security number may be disclosed to leave donors for the purpose of positively identifying leave recipients so that donated leave can be credited to the proper account.

Clear Form

AD-1046
Previous edition unusable (Rev. 4/89)